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Bulk Claim Denials by Insurer Leads to Higher Costs for Patients

ProPublica article highlights how Cigna denies claims based on medical necessity without opening the patient's file, leaving patients with unexpected bills

On March 25, ProPublica reports that, based on internal documents and reviews with former Cigna executives and doctors, Cigna's claims system is set up to deny many claims in bulk, without appropriate review by a medical director. Instead of using their medical expertise, a Cigna computer system flags claims where tests may not be acceptable for the diagnosis and medical directors are allowed to simply sign off on the denials in batches. The article further describes that the process is done knowing that many patients won't appeal, and instead will pay the out-of-pocket cost.

Cigna disagrees with the description of its claims system, but ProPublica notes that "over a period of two months last year, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of 1.2 seconds on each case…" The article quotes several former Cigna medical doctors as saying that the process took seconds and that they did not have to review files to deny a claim.

One former executive is reported to recognize that insurers benefit from the savings and further says that everyone stands to gain when health care costs are lowered and unneeded care is denied. However, in a statement by Cigna to ProPublica, Cigna emphasized that the system doesn't prevent patients from receiving care because these reviews occur after the care has been provided. Thus, how the system actually lowers overall health care costs, instead of simply shifting costs from the insurer to the patient, is not clear.

View the full *ProPublica* article.

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